WOODROW WILSON REHABILITATION CENTER
Fishersville, Virginia 22939

CLIENT REQUEST FOR ACCESS TO RECORDS

Client Name (printed): _____
(last, first, middle)

SSN: _____ or WWRC #: _____

Please read the following:

- All requests for copies of records must be in writing.
- If a client's representative is requesting the records, copies of supporting documents allowing access to the requested records must be available and identification will be required and verified.
- Woodrow Wilson Rehabilitation Center shall not be held liable to the client or any other person for any consequences which result from disclosure of client records.
- Upon request, Woodrow Wilson Rehabilitation Center may prepare a summary in lieu of allowing access to or copying of the entire record.
- IF the client was discharged within the last 21 days, the records shall be made available within 30 days from the date of request. (This is to allow time to complete the record.)
- Reasonable clerical costs shall be applied for making the records available such as locating, screening and copying. Clerical fees are $0.50 per page for the first 50 pages and $0.25 for each additional page for copying. Postage fees are additional.
- I hereby consent to the release of any and all records pertaining to my care at Woodrow Wilson Rehabilitation Center under the same consideration as above. I understand that such information can not be released without my specific consent, except under a Court Order.

Client's Name: _____ Date of Birth: _____
(Signature)

Address: _____

City/State/Zip: _____ Phone: _____

Dates of Service Needed: _____

Specific Portions Only (List): _____

To be filled out by a client's representative, if applicable.

Printed Name of Representative: _____

Signature of Representative: _____ Date: _____

Relationship of the Representative: _____

Witness: _____ Date: _____

Please submit this form by mail to:
Woodrow Wilson Rehabilitation Center
RECORDS MANAGEMENT SERVICES, Box W-484
PO BOX 1500
Fishersville, VA 22939-1500

MRD 2403
3/05